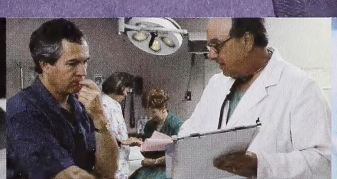
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[multi-disciplinary teams]

lessons learned







advancing
PRIMARY HEALTH CARE IN ALBERTA
sharing the learning

what is primary health care (PHC)?

Primary health care is **the first point of contact** of individuals with the health system – that is, where health services are mobilized and coordinated to promote health, prevent illness, care for common illness and manage ongoing problems (National Forum on Health, 1997). **Primary health care services** include: health promotion, illness and injury prevention, screening, health information, examinations, treatment in physicians' offices, vaccinations, home visits, nutritional counselling, drug dispensing, home care and so on. It involves a **variety of health professionals** including family physicians, nurses, public health nurses, nurse practitioners, pharmacists, mental health therapists, rehabilitation therapists, optometrists, home care providers, social workers and others.

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PREFACE

The Umbrella Alberta Primary Health Care Project was created to further advance primary health care by informing the practice of primary health care in Alberta and future policy development.

The Umbrella Alberta Primary Health Care Project finds its roots in the final report of the National Forum on Health (1997). The report recommended reform in key areas, including primary health care. It further recommended creation of a health transition fund to support evidence-based pilot and evaluation projects in health care. In response to those recommendations, the federal government created the Health Transition Fund (HTF) in 1997. It focused on four key areas:

- primary health care reform;
- integrated delivery of services;
- home care; and
- pharmacare.

Following consultation with stakeholders in 1997, Alberta Health and Wellness chose to focus on primary health care and submitted a proposal to the federal government. Alberta received an $11.2 million HTF grant in 1998 from the federal government, and the Umbrella Alberta Primary Health Care Project was created. An external selection committee reviewed primary health care project proposals from across the province, and 27 were ultimately recommended for funding. Most of the projects began in September 1998 and were completed by May 2000. Extensive dissemination activities by the Umbrella Alberta Primary Health Care Project and its 27 funded projects commenced in August 2000, including a provincial showcase conference and the development of diverse products to disseminate the learning. Detailed information on each of the 27 projects can be found at:
www.health.gov.ab.ca/key/phc/index.htm

SHARING THE LEARNING

While the projects were diverse, a number of common themes emerged from the final project reports and evaluation reports. Key findings in the areas of primary health care delivery, integration, multi-disciplinary teams, access and quality were compiled in a series of booklets, as well as other publications, designed to share the findings provincially and nationally as a contribution to the advancement of primary health care.

Multi-disciplinary teams are made up a variety of providers who work together to meet the needs of the defined population. They are effective and, in fact, a necessary means for delivering comprehensive care in a primary health care setting. But like any other team, they require careful planning, implementation and ongoing support. In this stand-alone booklet, we summarize the experiences of the 27 Alberta primary health care projects in creating effective multi-disciplinary teams.

The other materials can be obtained through Communications Branch, Alberta Health and Wellness, 22 Floor, Telus Plaza North Tower, 10025 Jasper Avenue, Edmonton, Alberta T5J 2N3. Telephone 780-427-7164.

Alberta Health and Wellness extends its thanks to the project teams, regional health authorities, partners, the evaluation management team (Howard Research Inc.) and the independent evaluation teams for their work in advancing primary health care in Alberta. It also thanks R.A. Malatest & Associates Ltd. and Dr. Leslie Gardner, who contributed to the development of this booklet, and our designers, Vision Design Communications Inc.



[multi-disciplinary teams] in primary health care

Many people assume that if you put a group of people together and give them a task, they will form a team. Any who have tried it know that **team-building is a purposeful task** that requires a common goal and includes individuals who are committed to that goal, who trust one another, are effective communicators, make decisions **as a group** and have processes that **support their work** as a team.

Multi-disciplinary teams are made up of a variety of **providers who work together** to meet the needs of a defined population. They are an effective and, in fact, a necessary means of delivering comprehensive care in a primary health care setting. But like any other teams, they require **careful planning, implementation and ongoing support.** In this booklet, we summarize the experiences of the 27 Alberta primary health care projects in creating effective multi-disciplinary teams.

The face of primary health care – A case for change

The pharmacist completed a medication history with one of the patients enrolled in the study (Primary Health Care Collectives). The conversation was cordial and the patient was an excellent historian. Halfway through the interview, when asked, "How do you think the medications are working for you?" the patient began to cry. He said, "I have issues that I could never talk to my doctor about. Things like being on a herbal preparation for my pain, or even that I am in so much pain that sometimes I can't bear it."

He went on to say that he cried a lot, for no known reason. As the conversation continued, the pharmacist realized that what the patient was describing needed to be addressed by his physician. When asked why he hadn't talked to his physician, the client responded, "I can't talk to him about this stuff, feeling low, and unable to cope. And what if I start crying?"

The pharmacist talked about the purpose of the study which was to have the pharmacist, home care nurse and physician working as a team; to identify patient care issues as a team and work with the patients to resolve those issues. The patient gave the pharmacist permission to discuss his situation with the physician.

The physician subsequently talked to the patient about the issues. The physician made a conscious effort, based on the information from the pharmacist, to open up communication and said "Let's talk." The physician suggested medication for depression, a suggestion that the patient initially rejected. However, by the time the conversation ended, the patient said he would give it a try.

With the medication and support from the physician, the patient improved dramatically. At the conclusion of the project, the patient contacted the pharmacist, thanking her for the care she provided. Both the patient and his wife were grateful to the team and said that his quality of life had improved immensely with their care and support.

From an interview with a pharmacist, Primary Health Care Collectives Project

(This project in Edmonton, created six teams of family physicians, pharmacists and home care nurse managers to improve the quality of medication use by high-risk patients/clients in the community.)

This story about a patient/client who was more comfortable discussing important health information with one provider than another, illustrates the benefit of sharing information among health care providers, and working as a team to resolve patient/client issues. Other benefits of a multi-disciplinary team approach in primary health care are:

- improved diagnosis and coordination of care with resulting improvements in health status;
- increased user satisfaction by improving access to a range of services, and ensuring fewer gaps in service;
- improved provider satisfaction resulting from the supportive team environment;
- increased cost-effectiveness achieved by meeting a variety of patient/client needs at a primary health care level. This reduces the need for more costly levels of care and avoids expensive duplication of services.

THE ROADBLOCKS

"They had seen many projects come and go and they looked at this project as just another 'Oh here we go again, try it for a year, everybody will do their thing and it will be over with.' So to overcome that idea and to develop some trust that we were really committed to making this work... that took time and that was probably the biggest barrier."

Tracey Smith, Public Health Services Coordinator, Health For All – Metis Settlement Project, Lakeland Regional Health Authority
(This project added a settlement nurse to four Metis settlements in the region.)

While the benefits of a multi-disciplinary approach to primary health care are evident, creating an environment conducive to teamwork within the current health care climate was challenging for many projects.

Barriers to successful multi-disciplinary teams included:

- the focus on autonomy in professional cultures;
- a lack of trust between professions and between projects and communities;
- different reporting structures for the various providers on the team;
- differing program mandates;
- lack of staff time to take on new responsibilities;
- different catchment areas;
- lack of incentives (particularly financial) to participate;
- legislative framework limiting the scope of professional practice;
- lack of support for primary health care within the community or the region;
- limitations of current information systems; and
- lack of formal evaluation criteria.

Health care professionals whose team activities are outside of their "paid" practice may be unwilling to participate.

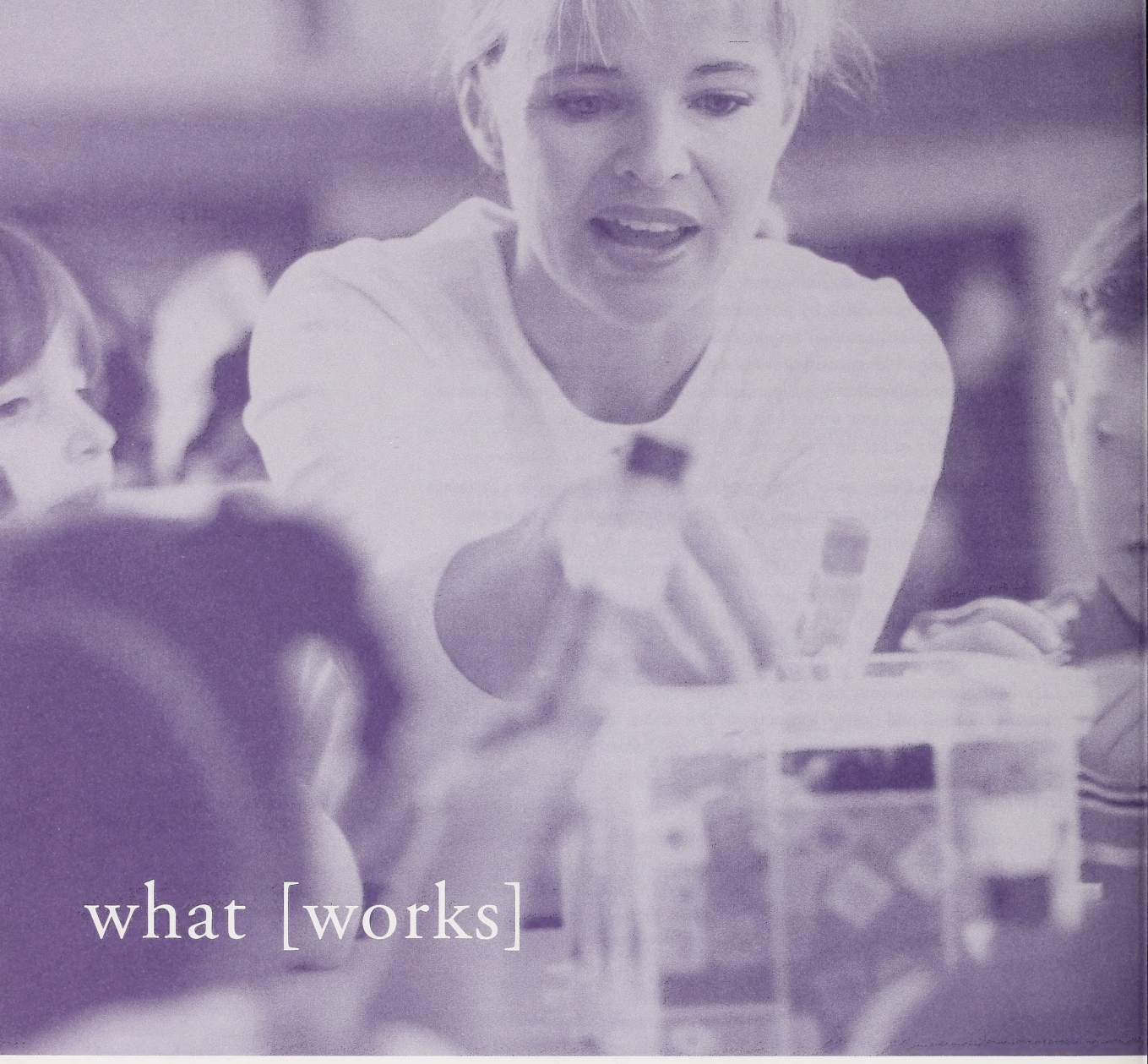
Current funding models do not support effective multi-disciplinary teams. Fee-for-service billing by physicians and other private providers (pharmacists, physiotherapists) impedes sharing information and collaborating in client care. For example, physicians can only claim fees for activities related to direct patient care even when their participation in team case management would have a significant impact on the health status and quality of life for a patient.

The **Community Outreach in Pediatrics/Psychiatry and Education Program (COPE)** has provided pediatric and child psychiatry outreach services to underserved disadvantaged children in public schools in Calgary's high-risk communities since 1997. The COPE Project found that physicians could not bill for consultations with other health care professionals unless the patient was present, despite the need for this type of consultation in many of the complex cases presenting at COPE.

Clearly, if physicians may not receive remuneration for public education, parent education and outreach functions, this makes it difficult to establish such programs or practices involving them. Health care professionals whose team activities are outside of their "paid" practice may be unwilling to participate.

> *"Our physicians are on an Alternate Payment Plan. What that means is that the physician can participate more fully with a multi-disciplinary team and can focus attention on some of the high-needs population groups that often don't get the kind of clinical time that we would like them to be able to access. I think it has freed our physicians to think a little more broadly about how they can participate on the team and how they can direct their energies to the people with the highest needs."*
>
> Marion Relf, Site Director, Northeast Community Health Centre in Edmonton (The Centre, established in 1999, provides primary health care services to the community in northeast Edmonton.)

Legislation was a barrier in the **Calgary Urban Project Society (CUPS) Project** (CUPS Community Health Centre is located in downtown Calgary). This project sought to meet the unique and high needs of underserved inner-city residents and wanted to add a nurse practitioner to their team. As nurse practitioners may only be employed by a regional health authority or board, an agreement was reached with the Calgary Regional Health Authority whereby the region employed the nurse practitioner who was then seconded to the CUPS Project. Legislation also stipulates that nurse practitioners may only be employed in a population defined by the Ministry of Health and Wellness as medically underserved. Special permission had to be obtained from the Minister for the nurse practitioner to work in the project.



what [works]

Creating and supporting multi-disciplinary teams is a **multi-faceted activity.** The 27 Alberta primary health care projects identified eight factors critical to forming successful multi-disciplinary teams:

- selecting the right team members;
- developing a common understanding of the vision and goals;
- involving all members in planning and coordination;
- defining roles and responsibilities;
- team-building;
- communicating effectively;
- providing adequate support for the teams; and
- conducting ongoing evaluation.

SELECTING THE RIGHT TEAM MEMBERS

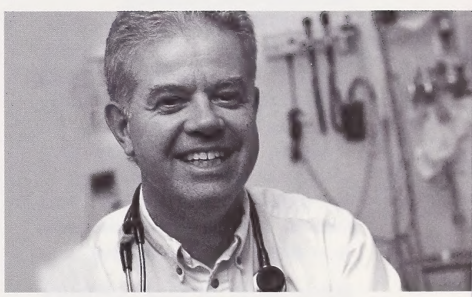
The first step in forming a multi-disciplinary team, identified by all the projects, was choosing providers with the right mix of skills and attitude to meet the needs of the client population.

the right mix of skills

The Community Outreach in Pediatrics/Psychiatry and Education (COPE) Project brought together health providers, teachers, and learning specialists to best meet the needs of children with mental health issues.

> *"As a result of COPE, there are people we can call on to say 'this is what the school's saying, this is what the system's saying, this is what the doctors are saying, this is what the therapist is saying, this is what the support team is saying.' Would you guys all talk together, because I don't have the skills to bring all those pieces together and interpret how they should interrelate. They need to talk to each other."*
>
> A COPE parent

In the **Shared Mental Health Care in Primary Care Practice Project** in the Calgary Regional Health Authority, physicians were supported by a team that included consulting psychiatrists, mental health nurses, a psychologist and a mental health worker. The multi-disciplinary team assembled for the



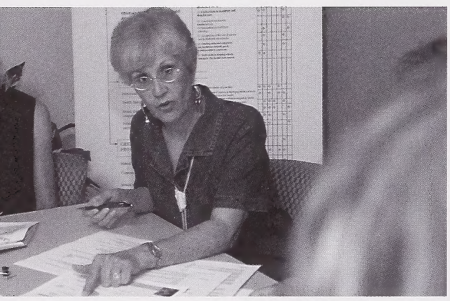
"A multi-disciplinary approach emphasizes the fact that each professional has their own special skills that they're good at. And you put a group of professionals who work together as a team. The patient gets the advantage of all that special intuitive group knowledge and the professions learn from each other as they work together as a unit."

Dr. Tom Szabo, Medical Director, 8th & 8th Health Centre, Calgary

The willingness of all members of the health care team to collaborate was key to the move to a new way of doing things.

The Lakeland Integrated Community-based Palliative Care Project team was comprised of physicians, home care nurses, social workers, physical therapists, occupational therapists and funeral directors. The **Healthy Families Project** in the Capital Health Region was an intensive home visitation program for higher risk families with their first child. The program was delivered through a partnership with three community-based agencies.

In all cases, the pilot and evaluation projects recognized the importance of addressing the specific needs of their target population when determining which services and skills should be represented on the team.



"At a staff retreat, we were able to talk about what we meant by 'multi-disciplinary team' and use qualitative data obtained through staff interviews. We were able to demonstrate that, even though the project had been operational for some time and the staff perceived themselves to be functioning as a multi-disciplinary team, that in fact, each of them was working side-by-side. They were not a cohesive team making decisions together about the provision of services to a defined group. It was very helpful to be able to look at that and define what we meant by a multi-disciplinary team. As a result, there has been tremendous movement to working together in new ways."

Jeanne Besner, Director of Primary Care Development, Calgary Regional Health Authority

attitudes conducive to collaboration

In addition to possessing the right skills, multi-disciplinary team members must also want to collaborate.

"In the beginning, the home care nurse manager didn't want her role changed – 'I make independent decisions' – very territorial, but that team came along and worked great because the desire was there to make it work."

Karen Farris, Ph.D., Principal Investigator, Primary Health Care Collectives Project

The ability and willingness of professionals to work together was a contributing factor in the success of the integration of a nurse practitioner into the CUPS Community Health Centre in Calgary. The introduction of the nurse practitioner required changes in the composition of the nursing staff and some shifts of roles and responsibilities. The willingness of all members of the health care team to collaborate was key to the move to a new way of doing things.

A collaborative attitude must include a willingness to share decision-making power. The person taking the lead may vary depending on the health needs of the client and on where the best relationship exists between client and health care provider. At the Northeast Community Health Centre (NECHC) in Edmonton, the lead on the team changed depending on the needs of the client or their first point of contact.

"We've really tried to think about the team of health professionals. And the leader of that team varies from time to time, from person to person. So it might be the nurse practitioner, it might be the physician, it might be the dietitian."

Marion Relf, Site Director, Northeast Community Health Centre, Edmonton

A COMMON UNDERSTANDING OF THE VISION AND GOALS

Although the terms *primary health care* and *primary care* are sometimes used interchangeably, primary health care is broader and more inclusive. Based on a holistic definition of health, primary health care typically involves a range of providers and an integrated approach to care. The starting point for a multi-disciplinary team is a common understanding of the principles that guide primary health care.

The principles listed below were identified in the study for Alberta Health and Wellness that reviewed Canadian and international documents on primary health care produced over the last five years. The principles were then revised based on feedback from key stakeholders, including regional health authorities, service providers and professional associations in the province.

The stated **principles of primary health care** are:

1. to encourage and facilitate individuals and communities to become as healthy as possible, recognizing the central importance of the broad determinants of health;
2. to promote and facilitate the participation of individuals and communities to take greater responsibility for their own health;
3. to focus on the specific needs, strengths, resources and issues facing a community in determining the service mix and how, when and where to offer services;
4. to deliver affordable, reliable and timely services accessible by community members according to their needs;
5. to respond to the priority health needs of the population, systematically identifying those at risk, and to reduce inequities in health status;
6. to use multiple strategies in addressing individual and population health issues. This includes community development approaches, inter-disciplinary teams in collaboration with volunteers and other agencies, and the use of non-traditional and alternative health workers as appropriate;
7. to provide seamless transition and integrated care delivery by effectively linking primary health care and secondary care;

8. to use appropriate and affordable technology and tools in conjunction with information systems management and linkages, to ensure continuous quality improvement, ongoing education, proper evaluation and research; and
9. to be accountable to community members, providers, regional health authorities and governments for the development and practice of sustainable and affordable primary health care.

INVOLVEMENT OF ALL MEMBERS IN GOAL-SETTING AND PLANNING

"It was important for us to give them the opportunity to learn. Our planner was able to help them come together and clarify their vision and their commitment, to define their role and help us (the health authority) define the role we would have to support them. That was one of our success points."

Sharon Jeffares, V-P of Health Services, East Central Health Authority
(East Central Health Authority established primary health care in four rural communities in its region.)



"I'm trained to handle common conditions throughout the life span. So, if someone comes in with a very straightforward condition and it's in my scope of practice, I can handle it easily. If it's beyond my scope of practice and comfort level, then I pass that patient on to the physicians. It really calls on the physician and nurse practitioner to work closely together. The foundation of that relationship is trust and mutual respect."

Chris Wood, nurse practitioner, CUPS

The vision and mission of the projects provide the "common ground" for the teams. According to the evaluation of the Northeast Community Health Centre (NECHC) in Edmonton, establishing a common mission and vision in the planning stages encouraged staff commitment to the vision and underpinned the successful functioning of the multi-disciplinary team. As the independent evaluators of the NECHC project said, the project's "early establishment of the vision/mission for the centre guided decision making and maintained focus on desired outcomes." *(Wilson et al. 2000, p. 2).*

Early inclusion promoted a sense of ownership and set the stage for positive relationship building, while the lack of early inclusion created challenges for a number of projects. The **Strengthening Multi-disciplinary Teams in Coordinated Disease Prevention and Management Project** brought together community-based health care practitioners in Calgary to improve prevention and treatment of diabetes and osteoarthritis through the development of care plans. However, the addition of new team members later in the project disrupted the team-building and communication processes established earlier.

During the second phase of the project, six multi-disciplinary primary health care teams were set up to implement the team plans. These teams were comprised of a mix of working group members (primarily supervisory) from phase one of the project and new members (mainly front-line practitioners). The overlap was important to ensure continuity, but also created its own challenge: more time was required for team-building to bring new members up to speed.



DEFINING ROLES AND RESPONSIBILITIES

"I have an even greater understanding of my team's workload, time constraints and the broad scope their jobs involve. When we work in an isolated cage, it's hard to truly understand what's going on in another professional's cage."

Pharmacist, Primary Health Care Collectives Project

To function efficiently, team members must understand and accept each other's roles and responsibilities. This allows the team to draw on one another's strengths. The clarification of roles and responsibilities also reduces duplication of effort and facilitates the delegation of tasks among team members.

TEAM-BUILDING

"If we hadn't had the time (for team-building), if you were just sort of thrown into it immediately, doing assessments, we would have continued operating from our own perspective."

Home Care Case Manager, Primary Health Care Collectives

Ongoing, facilitated team-building is important to ensuring that the team continues to function well, keeps communication lines open and continually improves the provision of care.

The **Primary Health Care Collectives Project** recommended that team-building processes begin prior to the provision of patient care. The project made use of a professional facilitator who worked with teams to help them identify roles and responsibilities, determine accountability and develop their own mission and team goals. Following these initial meetings, three additional relationship-building and team-building workshops were provided for collectives members. These helped the teams develop a sense of ownership for their own processes, negotiate and clarify what they needed in order to function and clarify their roles.



In another example, the Northeast Community Health Centre (NECHC) in Edmonton found that fostering a successful multi-disciplinary environment required strategies that allowed staff to get to know one another, including formal presentations by a staff group at meetings or to other service providers, case conferences, job shadowing, cross-service initiatives and social events.

> *"Knowing your colleagues is a fundamental precursor to being able to trust that individual; trust is a prerequisite for working with another in a multi-disciplinary and eventually inter-disciplinary milieu."*
>
> Collaboration in Action: The Story of Edmonton's Northeast Community Health Centre (2000)

The **Strengthening Multi-disciplinary Care Teams in Coordinated Disease Prevention and Management Demonstration Project** in Calgary developed a multi-disciplinary team approach to promote the prevention and treatment of chronic disease. The project provided multi-disciplinary working groups with internet-based decision-support tools to help them prepare care plans.

Team-building strategies that facilitated collaboration in the project were:

- structured, facilitated team-building workshops;
- on-line decision-support tools that allowed the team to review evidence, choose care recommendations, derive clinical practice tasks and prioritize the elements of team care plans; and
- on-line information tools that helped to identify the roots of disagreement between team members. The technology allowed for anonymous disclosure of disagreement and was most successful when the collection of comments was used as a basis for discussion in face-to-face sessions.

A formalized plan of how communications will be handled between team members should be developed at the beginning.

EFFECTIVE COMMUNICATION

Strong communication linkages are key to the smooth functioning of the multi-disciplinary team. A formalized plan of how communications will be handled between team members should be developed at the beginning of a project. All members of the team need access to the same client information (both paper and electronic records) to ensure that appropriate treatment plans are in place, to coordinate care and reduce duplication of effort. Co-location of services, team meetings and dedicated time for case conferencing are examples of communication tools that help teams function well.

The **Strengthening Multi-disciplinary Primary Health Care Teams in Coordinated Disease Prevention and Management Project** used Internet-based communication tools in developing their plans. However, as noted in the project evaluation report, "before a 'virtual' communication environment can be optimally used, face-to-face team communication must be established."

In the **Enhancing Primary Care of Palliative Cancer Patients Project** in the Calgary Regional Health Authority, a multi-disciplinary team was established to implement a quality improvement process. Their communications initiative included a standardized consultation note for physician communication to assist palliative care providers in identifying the expectations of patients, families and the other care providers.

"Standardized information and communication tools are critical to supporting multi-disciplinary involvement in the provision of primary health care services."



A standardized consultation note also proved helpful in integrating the health and school systems in the **Community Outreach in Pediatrics/ Psychiatry and Education Project** (COPE). The project report notes that numerous issues arose as a result of miscommunication. For example, the COPE physician would consult with the student and the student's family and then summarize the concerns and recommendations in a letter to the family physician. However, as the letter is considered a legal document, it could not be shared with the school. The team responded by developing a standard form for documenting recommendations from consultations and sharing them with the school.

The Northeast Community Health Centre (NECHC) in Edmonton developed a common client record that allowed important patient/client information to be shared among service providers. The **Lakeland Integrated Community-based Palliative Care Program (Project)** implemented a "Communication Passport" that included information about the patient/client's care such as pain, symptoms, changes in medication and appointments.

ADEQUATE SUPPORT FOR THE TEAM

Some of the necessary supports for multi-disciplinary teams have already been reviewed; namely, compensation for private practice professionals (particularly for activities not covered by the fee-for-service schedule), facilitated team-building, patient/client information systems and formalized communications.

The success of the team also depends on allocating adequate time and resources for:

- planning;
- involvement of the appropriate providers; and
- providers to manage their commitment to the team.

The above processes are often in addition to the health care providers' regular duties.

> *"The relationship between the employer and the home care nurse managers is governed by a collective agreement. The kind of flexibility to meet during lunch breaks, after hours or on days off that is possible for physicians and pharmacists was more difficult for the home care nurses. Additionally, the home care nurse's contribution was expected to be one day per week, but instead, the work requirement (for the project) was frequently in increments of one or two hours. This was much more difficult for the home care program to cover and costly to locate replacements."*
>
> Final Evaluation, Primary Health Care Collectives Project

What was described as "a day from hell," with lots of angry people, evolved into a natural sharing of information and perspectives.

ONGOING EVALUATION

"What does integration mean? How does it work? Does it mean we just share a coffee room? Or does it mean that we work together in a different way? What the evaluation made us do was really focus on what was working and what wasn't and helped us to put processes in place that really got us working together to jointly solve client problems."

Micheline Nimmock, 8th & 8th Health Centre, Calgary

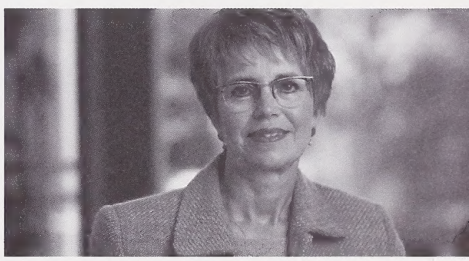
The Alberta primary health care projects found that determining how well the team is functioning and what needs refinement is only possible when an ongoing process of monitoring and evaluating forms part of the project from the beginning. The evaluation should assess such things as how well the team is coping, how clients are responding and whether the project objectives are being met.

"We decided that we were probably more of an environment than a team. We started shifting, making some structural changes to make us better positioned to be a multi-disciplinary team. Historically we had a psychological team, a community development team and a clinical team. Based on what we were seeing and hearing, we decided that what we needed was a family team and a seniors' team."

Chris McFarlane, Executive Director, Evaluation of the Alexandra Community Health Centre (The Alexandra Community Health Centre had served the needs of Calgary's inner-city population for the past 26 years in three program areas: clinical services, psychological services and community development.)

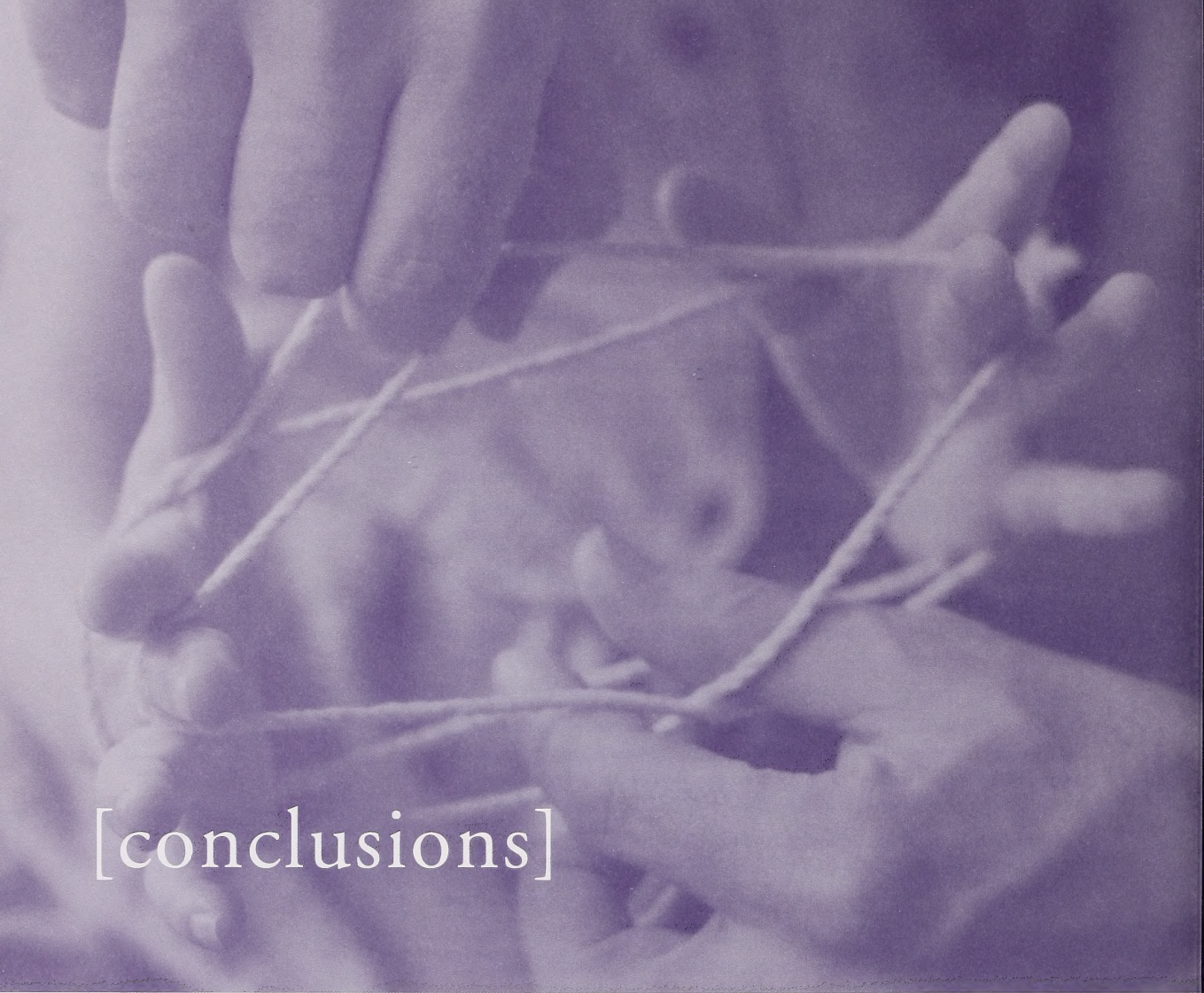
Based on information from the evaluation, the Alexandra Community Health Centre also changed its physical environment to promote integration on the teams. Clinical staff had traditionally occupied one side of the building with community development staff on the other side. Several of the clinical staff were moved to offices on the community development side of the building, and some of the community development staff moved to the clinical side. What was described as "a day from hell," with lots of angry people, evolved into a natural sharing of information and perspectives.

East Central Health Authority credits the involvement of an independent evaluator throughout its project with keeping the project true to its goals and objectives.



"If we got a bit too focused inward or more self-serving, or competitive, she (the evaluator) was there to check us and help us reflect on how well we were achieving what we set out to do, which was to serve people better."

Sharon Jeffares, East Central Health Authority



[conclusions]

"I think integration is at the very core of primary health care. If we don't move towards integrated systems, then I don't think we'll ever achieve the objectives of primary health care. Providers who traditionally have worked in isolation from each other need to come together as members of a multi-disciplinary team, each of whom has a unique and complementary role to the others."

Jeanne Besner, Director of Primary Care Development, Calgary Regional Health Authority

The experience of the Alberta primary health care projects in **creating multi-disciplinary teams is encouraging.** Projects were able to assess the difficulties they were having and make course corrections. Despite the challenges, it has proven to be **an effective and necessary means** of delivering successful primary health care.

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Multi-Disciplinary Teams: Lessons Learned (Booklet) NCN49
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www.health.gov.ab.ca/key/phc/index.htm

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